**Intro to Interviewing – August 31, 2011**

Objectives

1. Recognize commonly used interviewing techniques when presented with patient-physician dialogue
   1. Nonverbal communication
      1. Seating arrangement, eye contact, volume of voice, eye contact, head nodding
   2. Open-ended questions
      1. Use general questions to get the patient’s description of symptoms
   3. Focused Questions
      1. Helps focus the patient on a specific aspect of the problem
   4. Closed Questions
      1. Detailed question about specific information
   5. Continuers
      1. Encourages patient to say more without your input
   6. Reassurance
      1. Puts patient at ease, but don’t give false hope
   7. Confronting
      1. Draws attention to what the patient may be trying to avoid
   8. Silence
      1. Gives patient time to respond to difficult questions or venting feelings
   9. Echoing
      1. Encourages expansion in regards to details and feelings
   10. Transitions
       1. Tells patient when you are changing gears
   11. Summarization
       1. Draws all info together and clarifies it for patient
2. Describe the elements of a comprehensive health history
   1. Chief Complaint (CC)
      1. Why the patient came in their own words
   2. History of Present Illness (HPI)
      1. Amplifies CC using patient’s perspective and the 7 attributes
         1. Location, Quality, Severity, Timing, Setting, Better/Worse Factors, Symptoms, Meds, Allergies (with reaction), Substance Use (drugs, alcohol, and illicit drugs)
   3. Past History
      1. Includes childhood and adult illnesses and health maintenance (immunizations)
   4. Family History
      1. Health and illnesses of immediate family
   5. Personal and Social History
      1. Occupation, exercise, diet, and safety measures
   6. Review of Systems
3. Elicit a comprehensive health history from a standardized patient
   1. Do it.

**Building the Relationship – September 07, 2011**

Objectives

1. Recognize common relationship building skills
2. Use nonverbal, empathy, questioning and reflective skills
3. Establish physician and patient satisfactions through collaboration

Lecture

1. Use rapport and collaboration to build a relationship
2. Be prepared and attend to personal needs
3. Display active listening
   1. It increases patient trust, reveals problems, and prevents zoning out
4. Allow patient to finish their opening statement
5. Talk with patient to determine the next step and how to solve their problems
6. Use reflective listening to elicit more info from the patient
7. Make sure you don’t paternalize and have a Patient-Centered View
8. And show empathy and understanding since they are coming to you for help

**Societal Aspects of Interviewing and the Physician-Patient Relationship – September 14, 2011**

Objectives

1. Discuss the importance of attempting to deliver person-centered care
   1. Allows us to customize care and provide empathy for our patients while diminishing potential conflicts down the road
2. Define *culture* and discuss its various dimensions in medicine
   1. **Culture** is a set of learned and shared beliefs and values, that are applied to social interactions and the interpretation of experiences
   2. It influences how we experience illness and how we make health-care decisions
3. Discuss the difference between *disease* and *illness*
   1. Disease is an abstract way to explain problems defined using structure or function of body organs and systems
   2. Illness is an individual’s personal experience of ill health
4. Describe how culture relates to health… and illness
   1. Many people have differing views on illnesses and life and it may require you to work with the patient to come up with a plan that works for the patient and the doctor
5. Discuss the relationship between effective communication and delivery of quality health care
   1. How can a patient know what to do or even follow what is happening if they have no say in it or just simply don’t understand what is going on?
6. Describe two models used to promote cultural understanding in the practice of medicine
   1. LEARN model
      1. L – listen with sympathy and understanding to the individual’s perception of the problem
      2. E – Explain your perception of the problem
      3. A – Acknowledge and discuss differences and similarities
      4. R – Recommend treatment/solution
      5. N – Negotiate an agreement
   2. RESPECT model
      1. R – Rapport – Connect interpersonally
      2. E – Empathy
      3. S – Support – Help patient overcome fears
      4. P – Partnership – Collaboration is key
      5. E – Explanations – Check individual’s understanding
      6. C – Cultural Competence – Respect their beliefs
      7. T – Trust
7. Explain why physician – patient negotiation is important
   1. A plan that a patient comes up with is more likely to be followed because they had a say in it. It’s sort of like Inception

**Assessment of Family Violence – September 21, 2011**

* One in four women experience domestic violence throughout their life, typically from someone they know. Females ages 20-24 are most likely to experience IPV.
* Those who experience IPV are more likely to pass it on to the next generation.
* Stalking is very common and sexual assault is reported in 45% of IPV cases
* Homicides also have a high correlation with IPV
* Risk factors
  + Witnessing violence as a child
  + Experiencing violence as a child
* There is a huge socioeconomic cost to IPV in terms of medical expenses and indirect costs
* IPV also leads to psychological problems like anxiety, depression and suicide
* Physician’s Role
  + Don’t be scared to ask
  + Focus first on doing no harm
  + Use indirect techniques if you deem necessary (like for teens)
  + Make resources available for patients
  + Provide intervention by listening non-judgmentally and talking with patient
  + Don’t encourage confrontation
  + Overall, make the office a safe place to discuss problems

**Screening for Depression and Alcohol Misuse – September 21, 2011**

Objectives

1. Outline the diagnosis of Major Depressive Disorder
   1. Five or more of the following for at least 2 weeks
      1. Depressed or irritable Mood
      2. Sleep Problems
      3. Diminished Interest or Pleasure from most activities
      4. Feelings of worthlessness or Guilt
      5. Fatigue or loss of Energy
      6. Impaired Concentration or indecisiveness
      7. Change in Appetite or weight
      8. Psychomotor agitation or retardation
      9. Recurring thoughts of death or Suicide
      10. (SIGECAMPS)
2. Define types of alcohol misuse
   1. Risky drinking – Drinking way too much
   2. Problem drinking – drinking that results in physical, social, or psychological harm
   3. Alcohol abuse and dependence – Results in repeated harm, but unable to change pattern
3. Outline the use of paper and pencil screening tools for alcohol misuse and depression, including the PHQ-9 and the AUDIT
   1. AUDIT (Alcohol Use Disorder Identification Test)
      1. 10 questions about quantity and user’s experience
      2. 80% sensitive and specific for heavy drinking or dependence
   2. PHQ-9
      1. Questionnaire designed to identify patients that are depressed
      2. Low 90% for sensitivity and specificity
4. Utilize brief verbal screening techniques for depression and alcohol misuse, including the Two Question tool and the CAGE questions
   1. 2 question tool – used to determine depression
      1. “Over past 2 weeks, have you felt down, depressed or hopeless?”
      2. “Over past 2 weeks, have you felt little or no pleasure in doing things?”
      3. A positive answer to 1 or 2 questions is 85% sensitive and specific
   2. CAGE – 4 questions asked to determine alcohol problems
      1. Have you felt you should *cut down* on your drinking?
      2. Does criticizing your drinking *annoy* you?
      3. Do you feel bad or *guilty* about your drinking?
      4. Do you use an *eye opener* to steady nerves and get rid of a hangover?
5. Demonstrate interviewing techniques for difficult topics
   1. You have to bring the topic up yourself, since patients are reluctant to do so

**Documenting a Patient Encounter – September 26, 2011**

Objectives

1. Describe and recognize characteristics of “good” patient documentation
   1. Comprehensive/Clear/descriptive/Concise
   2. Legible/Accurate/Organized
   3. Stick to the facts
2. Discuss and apply techniques to minimize liability (risk management) when documenting a patient encounter
   1. Use approved abbreviations
      1. Write “unit”
      2. Write “daily” or “every other day”
      3. No trailing zeroes ( X mg) and have leading zeroes ( 0.X mg)
   2. NO altered records
   3. Correct records properly
      1. Strike-Thru (Initial, Date, Time, say “Error”)
   4. Add info properly
      1. Date, Time, Signature/Initials
3. Explain and identify components of a SOAP note
   1. S – Subjective – Info from patient or family
   2. O – Objective – Info from your observations/examination
   3. A – Analysis – Your impression or problem
   4. P – Plan – Your plan for treatment and follow-up
4. Document a patient’s chief complaint (CC) and history of present illness (HPI)
   1. DO IT

**Taking a Sexual History – September 28, 2011**

Objectives

1. To describe importance of taking a comprehensive and compassionate sexual history for wellness, addressing chief complaint, identifying high-risk behaviors, and primary prevention
   1. Lifesaving – Pregnancy, AIDS, STDs
   2. Could be related to another disease or could be a side-effect
   3. Risk management – STDs run rampant and need to be managed
   4. Sexual satisfaction
2. To examine one’s own attitudes toward sexuality and degree of comfort talking about sex with patients
   1. Don’t judge before treating the patient
   2. Use the proper terminology and don’t pull an Elliot Reed
   3. Remember that patients are scared to bring up this topic themselves and don’t want to get hurt so be respectful and know that you are doing it for them
3. To review general approach to taking sexual history through use of “*PLISSIT”* model
   1. P – Permission – allow the discussion to even take place
   2. L – Limited Info – Dispel myths and provide facts during your visit
   3. SS – Specific Suggestions – Give suggestions to the problem (small changes)
   4. IT – Intensive Treatment – Highly individualized therapy for complex situations (refer to the appropriate specialist)
4. To practice taking a sexual history with patient cases
   1. DO IT

**Communicating with LEP Patients – September 28, 2011**

Objectives

1. Discuss the legal and policy requirements for providing language access services (LAS)
   1. Title VI of the Civil Rights Act of 1964
      1. To get federal assistance, you must attempt to provide treatment for all races and languages
   2. National Standards for Culturally and Linguistically Appropriate Services in Health Care
      1. Must notify LEPs of their right to an interpreter and you must be able to cover the cost in order to receive federal funds
   3. Accrediting Organizations – The Joint Commission
      1. Must be able to provide interpretation and translation services to be accredited
   4. Hearing Impairments – Section 504 of the Rehab Act of 1973
      1. Must provide sign language interpreters
2. Describe the dis/advantages of various strategies for providing interpretation services
   1. Bilingual Staff – Must be competent to deal directly with LEPs
   2. Staff Interpreters – Can be expensive
   3. Contracted Interpreters – Cost-effective when a language it not seen often
   4. Telephonic Interpreters Lines – Speedy but no visual component
   5. Community Volunteers – Useful but must assess competence
   6. Family Member/Friend – Can be used but LEP should know about professional services
3. Recognize signs of professional and unprofessional interpretation
   1. Use Common Sense
4. Describe techniques to effectively guide an interpreter when conducting an interview with a limited-English proficient (LEP) patient
   1. Arrange seating with interpreter in background and guide interpreter’s role
   2. Use first person and talk to patient
   3. Short sentences and 1 question at a time
   4. No slang
   5. Remind interpreter of role if needed
   6. Avoid side conversations with interpreter